3 Pathology/Laboratory Service Guidelines

3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided by laboratories as deemed appropriate by IDHW. It addresses the following:

- Claims payment
- Prior authorization
- Healthy Connections
- Laboratory coverage and requirements
- Claims billing

3.1.2 Prior Authorization

Some pathology/laboratory services require prior authorization (PA). Please contact EDS at (800) 685-3757 to verify if the procedure requires PA.

EDS is not an authorizing agency for any Medicaid services and does not issue PA.

If PA is required, the PA number must be indicated on the claim in the appropriate field, or the service will be denied.

3.1.3 Healthy Connections (HC)

Check eligibility to see if the client is enrolled in Healthy Connections (HC), Idaho's Medicaid Primary Care Case Management (PCCM) model of managed care. If a client is enrolled, a referral is required from the HC Primary Care Provider (PCP) before payment can be made. See **Section 1.5, HC**, for more information.

See **Section 2.3, General Billing Information,** for more information on billing services that require Prior Authorization.

Note: Laboratory testing for most transplants are not covered for **CHIP-B** participants.

Refer to the **CHIP-B Appendix section B.1.5** for service limitations for **CHIP-B** participants.

3.2 Laboratory Coverage

3.2.1 Independent Laboratories

Independent laboratories are not affiliated with a specific physician's office and must have a separate provider number. They may provide testing for multiple groups of physicians. However, independent laboratories must bill Idaho Medicaid directly for the services they render.

Independent laboratories must hold a current Clinical Laboratory Improvement Amendments (CLIA) certificate before Medicaid will reimburse for testing performed in the laboratory. Payments may be denied to any laboratory submitting claims for services not covered by a CLIA certificate and for services rendered outside the effective dates of a CLIA certificate. A current CLIA certificate must be on file with EDS.

3.2.2 Laboratory Procedures

Only the following CPT lab codes can be broken out into a professional and technical component:

- 88104 through 88125
- 88160 through 88162
- 88172 through 88173
- 88180 through 88182
- 88300 through 88319
- 88323
- 88331
- 88342 through 88365

Pathologists who own an office/laboratory and equipment may be paid for the complete test. This includes tests that cannot be broken out into the professional and technical components.

3.2.3 Diagnosis Code

Always indicate a valid diagnosis code on the claim form. If the correct diagnosis is unavailable, enter ICD-9-CM diagnosis code **V72.6** for the primary diagnosis in field 21 on the CMS-1500 claim form. For clients enrolled in the Pregnant Women (PW) or Presumptive Eligibility (PE) programs, see **Section 3.2.6**.

3.2.4 Venipuncture

Use procedure code **36415** for routine venipunctures and collection of specimens.

3.2.5 Special Services

Handling and conveyance of specimens for transfer to a laboratory from place of service **12** (residence) or **32** (nursing home) are covered by Medicaid when billed with procedure code **99001**.

3.2.6 Presumptive Eligibility/Pregnant Woman Services

Services rendered to Medicaid clients eligible for the Presumptive Eligible (PE) or Pregnant Woman (PW) programs must have a pregnancy diagnosis or documentation to substantiate how the service was pregnancy related. When in question, the laboratory provider should attach a signed PW medical necessity form from the referring physician to their claim.

For more information on PE and PW, see **Section 1.4, General Provider and Client Information**, *Restricted Medical Coverage*. Providers can obtain the pregnancy related Medical Necessity Form at: **http://www.healthandwelfare.idaho.gov/DesktopModules/Documents/DocumentsView.aspx?tabID=0&ItemID=4442&MId=11623&wversion=Staging**

3.2.7 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Federal requirements mandate that all Medicaid eligible children ages 12 months and again at 24 months be tested for lead poisoning. The U.S. Centers for Disease Control (*Preventing Lead Poisoning in Young Children,* October 1991) no longer recommends the use of erythrocyte protoporphyrin (EP) for blood lead level testing. Idaho Medicaid follows the American Academy of Pediatrics periodicity schedule.

3.2.8 Place of Service Codes

Enter place of service code **81** when billing for services in an independent laboratory.

3.2.9 Modifiers

When a repeat procedure is ordered on the same day for the same client, report with modifier **91**. Modifier 90 is not currently accepted by the Idaho Medicaid program.

3.3 Claim Billing

3.3.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red CMS-1500 claim forms.

All claims must be received within one year of the date of service.

3.3.2 Electronic Claims

For PES software billing questions, consult the Idaho PES Handbook. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

See **Section 2** for more information on electronic billing.

3.3.2.1 Guidelines for Electronic Claims

Detail lines
Idaho Medicaid allows up to **50** detail lines for electronic HIPAA 837 Professional claims.

Referral number
A referral number is required on an electronic HIPAA 837 Professional claim when a client is referred by another provider. Use the referring provider's Medicaid provider number, unless the client is a Healthy Connections client. For Healthy Connections clients, enter the provider's HC referral number.

Prior authorization (PA) numbers
Idaho Medicaid allows more than one PA number per electronic HIPAA 837 Professional claim. PAs can be entered at the header or detail of the claim.

Modifiers
Up to **four** modifiers per detail are allowed on an electronic HIPAA 837 Professional claim.

Diagnosis codes
Idaho Medicaid allows up to **eight** diagnosis codes on an electronic HIPAA 837 Professional claim.

Electronic crossovers
Idaho Medicaid allows providers to submit electronic crossover claims for Professional services.

3.3.3 Guidelines for Paper Claim Forms

For paper claims, use only original red CMS-1500 claim forms to submit all claims to Idaho Medicaid. CMS-1500 claim forms are available from local form suppliers.

All dates must include the month, day, century, and year.

Example: July 4, 2004 is entered as 07/04/2004

3.3.3.1 How to Complete the Paper Claim Form

The following will speed processing of paper claims:

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly so it prints evenly in the appropriate field.
- Keep claim form clean. Use correction tape to cover errors.
- Enter all dates using the month, day, century, and year (MM/DD/CCYY) format. Note that in field 24A (From and To Dates of Service) there are smaller spaces for entering the century and year. Refer to specific instructions for field 24A.
- A maximum of six line items per claim can be accepted. If the number of services performed exceeds six lines, prepare a new claim form and complete all the required elements. Total each claim separately.
- You can bill with a date span (From and To Dates of Service) **only if** the service was provided every consecutive day within the span.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed unless EDS has a signature on file.
- Do not use staples or paperclips for attachments. Stack the attachments behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.3.3.2 Where to Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.3.3.3 Completing Specific Fields on the Paper Claim Form

EDS denies incomplete claims, so make every effort to provide valid, complete information as specified on the claim form.

The following numbered items correspond to the CMS-1500 claim form and includes only those fields that are required for Medicaid billing. Claim processing will be delayed when required information is not entered into any required field.

Field	Field Name	Use	Directions
1a	Patient ID	Required	Enter the seven-digit client Medicaid ID (MID) number exactly as it appears on the plastic client ID card.

Field	Field Name	Use	Directions
2	Patient's Name	Required	Enter the client's name exactly as it appears on the Medicaid plastic ID card. Be sure to enter the last name first, followed by the first name and middle initial.
9a	Other Insured's Policy or Group Number	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the policy and group number.
9d	Insurance Plan Name or Program Name	Required if applicable	Required if field 11d is marked YES. If the client is covered by another health insurance or medical resource, enter the plan name or program name.
10a	Is Condition Related to Employment?	Required	Indicate yes or no if this condition is related to the client's employment.
10b	Auto Accident?	Required	Indicate yes or no if this condition is related to an auto accident.
10c	Other Accident?	Required	Indicate yes or no if this condition is related to an accident.
11d	Is There Another Health Benefit Plan?	Required	Check yes or no if there is another health benefit plan. If yes, return to and complete items 9a-9d.
17	Name of Referring Physician or Other Source	Required if applicable	Use this field when billing for a consultation or Healthy Connections client. Enter the referring physician's name.
17a	ID Number of Referring Physician	Required if applicable	Use this field when billing for a consultation or Healthy Connection client. Enter the referring physician's Medicaid provider number. For Healthy Connections clients, enter the provider's Healthy Connections referral number.
19	Reserved for Local Use	Required if applicable	If applicable, all requested comments for claim submission should be entered in this field. For example, enter injury information, including how, when, and where the injury occurred if another party is liable. Use this field to enter ICN of previous claim(s) to document timely filing for claim resubmission.
21 (1-4)	Diagnosis or Nature of Illness or Injury	Required	Enter the appropriate ICD-9-CM code (up to 4) for the primary diagnosis and, if applicable, second, third, and fourth diagnosis. Enter a brief description of the ICD-9-CM primary and, if applicable, second, third, and fourth diagnosis.
23	Prior Authorization Number	Required	Enter the prior authorization number from Medicaid, DHW, RMS, ACCESS, RMHA, EDS, Quality Improvement Organization (QIO), or MTU.
24A	Date of Service — From/To	Required	Fill in the date(s) the service was provided, using the following format: MMDDCCYY (month, day, century, and year). **Example:** November 24, 2003 becomes 11242003 with no spaces and no slashes.
24B	Place of Service	Required	Enter the appropriate numeric code in the place of service box on the claim.
24D 1	Procedure Code Number	Required	Enter the appropriate five-character CPT or HCPCS procedure code to identify the service provided.
24D 2	Modifier	Required if applicable	If applicable, add the appropriate CPT or HCPCS modifier(s). Enter as many as three. Otherwise, leave this section blank.
24E	Diagnosis Code	Required	Use the number of the subfield (1-4) for the diagnosis code entered in field 21.
24F	Charges	Required	Enter your usual and customary fee for each line item or service. Do not include tax.

Field	Field Name	Use	Directions
24G	Days or Units	Required	Enter the quantity or number of units of the service provided.
24H1	EPSDT (Health Check) Screen	Required if applicable	Not required unless applicable. If the services performed constitute an EPSDT program screen, refer to the instructions for EPSDT claims in the provider handbook.
24K	Reserved for Local Use	Required if applicable	When a group, agency, or clinic is the billing agency, enter the Idaho Medicaid provider number of the individual provider rendering the service in Field 24K and the group provider number in field 33 GRP #.
28	Total Charge	Required	Add the charges for each line then enter the total amount.
29	Amount Paid	Required	Enter any amount paid by other liable parties or health insurance payments including Medicare. Attach EOB from other insurance company showing payment or denial, reason codes (with an explanation of codes), and the date the claim was processed.
30	Balance Due	Required	Enter the total charges, less amount entered in amount paid field.
31	Signature and Date	Required	The provider or the provider's authorized agent must sign and date all claims. If the provider does not wish to sign or signature stamp each individual claim form, a statement of certification must be on file at EDS. See **Section 1.1.4** for more information.
33	Provider Name and Address	Required	Enter your name and address exactly as it appears on your provider enrollment acceptance letter or RA. If you have had a change of address or ownership, please, immediately notify Provider Enrollment, in writing, so that the Provider Master File can be updated.
33	GRP# - Group Provider Number PIN # - Individual Provider Number	Required	Enter your nine-digit Group Medicaid provider number. in GRP#. Enter your nine-digit Individual number in PIN #..

3.3.3.4 Sample Paper Claim Form

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statement on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)
APPROVED OMB-0938-0008

PLEASE PRINT OR TYPE

FORM CMS-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500